STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065427	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Park West Llc, The	3727 Parker Blvd Pueblo, CO 81008

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48112 Based on observations, record review and interviews, the facility failed to keep medical records in a secure and confidential manner. Specifically, the facility failed to ensure nursing staff logged off their workstation when leaving the work area to protect the confidentiality of resident information. Findings include: I. Facility policy and procedure A request for a protected health information policy was requested on 8/1/24, but was not received. II. Observations On 7/30/24 observations were made on the second and third floor units. The second and third floors each had a nurses station in the middle of the unit with five to seven computer monitors. The second and third floor units had three hallways with resident rooms. Each hallway had a computer at a workstation in the middle of the hallway. The second and third floor units had three medication carts with a computer. Residents, visitors and families frequently walked down the hallways and by the nurses station, which enabled the computers to be visible to anybody walking by. At 2:42 p.m. an unidentified nurse left her computer screen, with a resident's electronic medical record (EMR) open, at the third floor nurses station. At 2:47 p.m. an unidentified certified nurse aide (CNA) left her computer screen, with a resident's EMR open, in the hallway at the third floor nurses station. At 3:00 p.m. a computer screen was left unattended, with a resident's EMR open, on a second floor medication cart. At 3:00 p.m. a computer screen was left unattended, with a resident's EMR open, on the second floor hallway desk workstation. An unidentified resident was sitting in a wheelchair next to an unidentified CNA. The unidentified resident was looking at the computer monitor. On 7/31/24 the following observations were made on the third floor unit: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:18 a.m. licensed practical nurse (LPN) #1 left her computer screen open, with a resident's EMR visible, at the nurses station. At 11:15 a.m. LPN #1 left her computer screen open, with a resident's EMR visible, at the nurses station. Two family members walked by the nurses station and Resident #99 came out of her room to the nurses station. At 12:41 p.m. LPN #1 left her computer screen open, with a resident's EMR visible, at the nurses station. On 7/31/24 observations were made on the third floor unit with the nursing home administrator (NHA) and the director of nursing (DON). At 2:46 p.m. a computer screen was left open, with a resident's EMR visible, in the hallway. The DON locked the computer screen. At 2:47 p.m. a computer screen was left open, with a resident's EMR visible, at the third floor nurses station. The DON locked the computer screen. III. Staff interviews CNA #5 was interviewed on 8/1/24 at 10:40 a.m. CNA #5 said residents' EMRs should not be left open on the computers where they were easily accessible to non-staff members. She said she needed to log off her workstation when she left the work area. LPN #2 was interviewed on 8/1/24 at 8:54 a.m. LPN #2 said the residents' EMRs with personal health information should not be left open and easily accessible to non-staff members. She said the nurses needed to log off their workstations when leaving the work area. LPN #1 was interviewed on 8/1/24 at 9:26 a.m. LPN #1 said the resident's EMRs with personal health information should not be left open and easily accessible to non-staff members. She said the nurses needed to log off their workstations when leaving the work area. The NHA was interviewed on 7/31/24 at 2:44 p.m. The NHA said the staff needed to log off their workstation when they left their workstation. He said the residents should not sit right next to nurses or CNAs who had resident medical record information visible on the computer monitor. The NHA said it was important to not leave the monitors unattended to keep resident medical information private.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure residents were provided an environment as free of accident hazards as possible for one (#32) of two residents reviewed for accidents and hazards out of 40 sample residents. Specifically, the facility failed to: -Ensure a thorough investigation was conducted after a skin tear was acquired during a staff-assisted transfer for Resident #32; and, -Identify the root cause of Resident #32's skin tear. Findings include: I. Resident #32 A. Resident status Resident #32, age 83, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes, interstitial pulmonary disease (lung disorder), heart failure, atrial fibrillation, morbid obesity and unsteadiness on her feet. The 6/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial assistance for toileting. She was dependent on staff for showering, dressing and transfers. She required supervision for oral hygiene and personal hygiene. B. Resident interview and observation Resident #32 and the resident's representative were interviewed together on 7/29/24 at 2:28 p.m. Resident #32 said the certified nurse aide (CNA) went too fast during her toileting care on 7/27/24 during the day shift. She said the CNA brought the walker to her while she was seated on the toilet. Resident #32 said she used the walker to transfer from the toilet to her wheelchair. She said the CNA went too fast when she placed the walker in front of her and caused a skin tear on her left shin. Resident #32 said the day shift nurse put a bandaid on the skin tear. She said the skin tear bled through the bandaid. She said she did not have proper skin care until the night shift nurse arrived. She said it was important to her to have good skin care because she had edema in both of her lower extremities. Resident #32 said her doctor told her that her skin was very fragile and she needed to be careful because it was easy to tear her skin. During the interview, Resident #32's left lower leg was observed with a white bandage which was loosely wrapped around the resident's left shin. She had swelling in both of her lower extremities and her legs were dry. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Skin tear observation On 7/31/24 at 12:07 p.m., wound care of the skin tear was observed. Resident #32 had an L-shaped skin tear on her left lower extremity that was approximately four and a half centimeters (cm) by one cm. The skin tear was on the upper left side of her left shin. D. Record review Resident #32's skin breakdown care plan, revised 6/14/24, revealed the resident had the potential for skin breakdown related to impaired mobility secondary to weakness and debility. Interventions included applying moisturizer to the skin and performing a Braden Scale assessment (a tool used to predict the risk of developing pressure injuries) every week and as needed. Resident #32's edema care plan, revised 7/31/24 (during the survey), revealed the resident was at risk for skin injury due to edema of bilateral lower extremities. Interventions included administering medications per physician's orders, elevating the resident's legs as tolerated, monitoring weight and monitoring for signs and symptoms of fluid overload as needed. Resident #32's skin tear care plan, revised 7/30/24 (during the survey), revealed the resident had a skin tear to the left lower extremity related to assistive device use. Interventions included encouraging good nutrition and hydration, identifying potential causative factors if skin tears occurred, using caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp and hard surface, placing tennis balls on the resident's walker, treating the skin tear per facility protocol and notifying the physician. The 7/27/24 nurse progress note revealed Resident #32 sustained a skin tear during the day shift on her left lower extremity. The wound was oozing and bleeding. The note documented the wound was cleaned with normal saline, covered with an ABD (abdominal) pad and wrapped with Kerlix (gauze) until the wound nurse was able to put new orders in. The wound nurse was messaged. The 7/28/24 nurse progress note revealed an as needed wound care was provided at the resident's request for a saturated dressing. -A review of the resident's electronic medical record (EMR) revealed there was no documentation by the day shift nurse on 7/27/24 that described how the skin tear occurred, skin assessment, pain assessment, who was notified and what orders were obtained for treatment of the skin tear. -There were no new care plan interventions added to prevent further skin tears for the resident until 7/30/24 (during the survey). The August 2024 CPO revealed the following physician's order: Wound care, cleanse the open area to left lower extremity with normal saline or wound cleanser, pat dry, apply xeroform (a moist wound dressing) to open area, cover with ABD pad, wrap with kerlix daily and as needed, ordered 7/28/24. II. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #5 was interviewed on 8/1/24 at 10:40 a.m. CNA #5 said she knew if a resident required assistance with toileting based on the shift change report, information on the vital signs sheet and on the white board in the resident's room. She knew if a resident needed one or two-person assistance based on the white board and she asked the resident. She said she knew if assistive devices were required with toileting based on the white board and vital signs sheet. CNA #5 said if she noticed a skin injury during toileting care, she finished the care then told the nurse about the skin tear. She said skin injuries included bed sores, weeping of skin, bruises and skin tears. She said she was familiar with Resident #32. CNA #5 said the resident required two-person assistance with toileting. CNA #5 said one person helped the resident stand while the other staff member provided toileting care. She said she saw the bandage on Resident #32's shin but the resident did not tell her what happened. CNA #5 said she was not told what happened to her shin. After the interview, the vital signs sheet was reviewed with CNA #5. The vitals signs sheet document revealed Resident #32 required an extensive two-person assist. Licensed practical nurse (LPN) #1 was interviewed on 8/1/24 at 9:26 a.m. LPN #1 said the CNAs knew if a resident required assistance with toileting based on the report from the hospital when they were admitted . She said the hospital report usually had a physical therapy (PT) and occupational therapy (OT) evaluation. She said the PT/OT evaluation said if assistance was needed and how much assistance. LPN #1 said if there was not an evaluation, she did two-person assistance until the facility's therapists completed an evaluation. LPN #1 said the CNAs asked the nurses if a resident required assistance with personal care. LPN #1 said skin tears happened because accidents happen. She said if a skin injury happened, she called the doctor to obtain an order, referred to the skin protocol and started the risk management module. LPN #1 said the risk management module for a skin tear included a section that described what happened, who was contacted and if physician's orders were obtained. Registered nurse (RN) #1 was interviewed on 7/31/24 at 3:18 p.m. RN #1 said if she noticed a new skin injury, she told the wound nurse. RN #1 said she worked the night after the skin tear occurred for Resident #32. She said she went to the resident's room and saw the skin tear weeping. She said she used her nurse's judgment to clean the wound. She said did not notice a bandaid on the skin tear. RN #1 said Resident #32 told her the skin tear happened when the day shift CNA helped her transfer from the toilet to the wheelchair. RN #1 said the resident told her the day shift nurse placed a band aid on the wound. RN #1 said she did not notify the physician, obtain wound care orders or complete a head to toe assessment. RN #1 said the skin tear happened during the day shift so the day shift nurse was responsible for notifying the physician and obtaining wound care orders. RN #1 said she documented what she did as a progress note in the resident's chart. -However, Resident #32 told RN #1 how she obtained the skin tear and there were no additional measures put in place to prevent the skin tear from occurring again (continued on next page)

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	065427	A. Building B. Wing	08/01/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home administrator (NHA) was interviewed on 7/30/24 at 1:43 p.m. The NHA said the nurse who worked the day shift did not complete an incident report on the day of the incident. The NHA said the nurse was coming in to complete the incident report when he returned from vacation. The NHA said an investigation regarding the skin tear was underway (during the survey) to determine what happened with the resident. The NHA said a request was made to nursing services for what immediate interventions were put in place to prevent the skin tear from occurring again. The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 7/31/24 at 9:44 a.m. The DON reviewed the incident report for Resident #32's skin tear. The DON said the incident revealed the root cause was the walker hit the resident's shin and caused a skin tear. The DON said the intervention was to complete wound care and individual staff education. The DON said the intervention put in place was for wound care but an immediate intervention to prevent the skin tear from occurring again was not completed. The resident's care plan was reviewed with the DON. The DON said the care plan was updated for wound care but the care plan was not updated to include interventions to prevent the skin tear from occurring again. The DON was interviewed again on 7/31/24 at 3:47 p.m. The DON said when the staff noticed a new skin injury,the nurse needed to notify the physician and the resident's representative The DON said the staff needed to notify the DON for risk management to be completed and obtain wound care orders from the physician. The DON said the nurse should add interventions, monitor for signs and symptoms of infection and complete a head to toe assessment, including the actual injury site. The DON said the nurse told the wound nurse about the wound so the wound nurse could determine if she needed to follow the resident's wound. The DON said the nurse documented the skin injury when the risk management module was triggered. The DON said the risk management module was not part of the resident's EMR. She said the risk management module had a section where the nurse was supposed to describe what occurred. She said this section was transferred to the resident's EMR as a progress note. The DON said the 7/27/24 skin tear was not investigated until 7/30/24 (during the survey). The DON said the investigation did not start because the nurse was on vacation and the DON wanted the nurse to complete the investigation report. The DON said she did not identify the skin tear as an accident. The DON was interviewed again on 8/1/24 at 11:01 a.m. The DON said the CNAs knew a resident required assistance with toileting, assistive devices and the type of assistance based on the Kardex (an abbreviated care plan for staff), tasks and the white board in the resident's room. The DON said if a CNA noticed a skin injury they told the nurse. She said Resident #32 required one-person assistance. The DON said the CNAs might have said the resident required two-person assistance because the CNAs preferred the additional assistance. The DON said Resident #32's skin tear happened because the skids on her walker's legs tore the resident's skin on her shin. The DON said she did not interview the nurse or the CNA because the nurse was on vacation and the CNA was not scheduled to work until 8/2/24. The DON said she did not interview any other staff or other residents. The DON said the ADON interviewed the resident. III. Facility follow up (continued on next page)

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	065427	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Park West Llc, The	3727 Parker Blvd Pueblo, CO 81008

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON provided the following information on 8/2/24. Resident #32 obtained a skin tear on 7/27/24 during a transfer. The CNA moved the walker in front of the resident and hit her left lower extremity, causing the skin tear. The CNA immediately reported the incident to the nurse on duty who assessed the injury and notified the provider. The provider gave verbal orders to cleanse and place a bandage, which the nurse did. The skin tear was passed on in the report so the night shift nurse contacted the wound nurse who collaborated with the provider for the new order due to increased drainage. The day shift nurse performed the original assessment and treatment. The nurse progress note revealed on 7/27/24, the CNA reported a small skin tear on the resident's leg during a transfer. The provider and family were notified. A physician's order was obtained to cleanse and cover the skin tear with a bandage. Treatment was performed and the wound care nurse was notified. The resident denied pain. On 8/2/24, on the spot training and education for safe transfers with a walker was completed with the staff involved in the incident on 7/27/24.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goal for one (#32) of two residents out of 40 sample residents. Specifically, the facility failed to, for Resident #32: -Ensure a pain assessment was completed that identified the type of pain, the effects of pain on the resident, the aggravating factors and the relieving factors; -Ensure person centered non-pharmacological interventions for pain management were offered and monitored for effectiveness; and, -Ensure the administration of pain medications was documented consistently. Findings include: I. Resident #32 A. Resident status Resident #32, age 83, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes, interstitial pulmonary disease (inflammation and scarring that made it hard for lungs to get oxygen), heart failure, atrial fibrillation (irregular and often rapid heart rhythm), morbid obesity and unsteadiness on her feet. The 6/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required substantial assistance for toileting. She was dependent on staff for showering, dressing and transfers. She required supervision for oral hygiene and personal hygiene. The assessment revealed the resident did not have a pain management regimen. The resident took pain management as needed and received non-medication interventions for pain. The MDS assessment documented the resident had pain frequently, which occasionally affected her sleep and her day-to-day activities. The resident reported her pain as moderate. B. Resident interview Resident #32 was interviewed on 7/29/24 at 2:28 p.m. Resident #32 said she sometimes had pain in different locations on her body. Resident #32 said she did not like to take pain medications. She said the facility did not offer non-pharmacological interventions when she experienced pain. She said if the lighting in her room was lowered, it would help her pain. C. Record review (continued on next page)

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	065427	A. Building B. Wing	08/01/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32's pain care plan, revised 8/1/24 (during the survey), revealed the resident had acute and chronic pain related to joint pain, peripheral vascular disease (blood circulation is reduced to a body part), interstitial lung disease and diabetes. She did not want to take pain medications and preferred non-pharmacological interventions. Interventions included acknowledging the presence of pain and discomfort, administering pain medications and monitoring for effectiveness, implementing non-pharmacological interventions, monitoring for pain every shift and notifying the physician as needed. Resident #32's opioid medication care plan, revised 6/17/24, revealed the resident took opioid medication for pain relief. The intervention was to monitor for side effects of dependence, nausea, vomiting, constipation, itching, respiratory depression and addiction. Resident #32's comfort care plan, revised 6/25/24, revealed the resident was at the facility for comfort care with minimal therapy. She received pain medications as ordered to keep her comfortable. Interventions included administering pain medication as ordered, notifying the physician if pain continued, providing a calm dimly lit environment, providing incontinence care and repositioning throughout the shift. -The care plan did not identify the location of her pain. The 6/13/24 admission pain assessment revealed the resident reported her pain was a 5 on a scale of 1 to 10. Her pain level, based on a verbal scale, was moderate. Her acceptable pain level was a 3 out of 10. She said she had pain in her knees, left arm and shoulders. The assessment documented the pain started years ago and the pain was constant and sharp. Voltaren gel and Advil helped her pain and movement made her pain worse. The 6/17/24 comprehensive pain assessment revealed the resident's pain, based on a verbal scale, was moderate. She had pain in her abdomen. -The type of pain, effects of pain on the resident's life, aggravating factors, relieving factors and associated symptoms portions of the assessment were not documented. The 7/27/24 comprehensive pain assessment revealed the resident's pain, based on a verbal scale, was moderate. She had pain in her abdomen. -The type of pain, effects of pain on the resident's life, aggravating factors, relieving factors and associated symptoms were marked as unable to determine. The August 2024 CPO revealed the following physician's orders: Voltaren gel 1%. Apply two grams transdermally every six hours as needed for chronic joint pain, ordered 6/13/24. Oxycodone five milligrams (mg). Take one tablet by mouth every four hours as needed for a pain level of 6 to 10 on a scale of 1 to 10, ordered 6/14/24. Tramadol 50 mg. Take one tablet by mouth every six hours as needed for a pain level of 1 to 5 on a scale of 1 to 10, ordered 6/14/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065427	A. Building B. Wing	08/01/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate pain every shift and document, ordered 6/13/24. -A review of the resident's August 2024 CPO did not reveal a physician's order for non-pharmacological pain interventions and non-pharmacological interventions were not monitored for effectiveness. On 6/28/24, 6/29/24, 6/30/24, 7/3/24, 7/4/24, 7/5/24, 7/6/24 7/7/24, 7/8/24, nurse progress note revealed the resident had pain. She had a pain level of 2 out of 10 on a scale of 1-10. The location of the pain was generalized. The action taken was repositioning, immobilization of the affected area and pain medication. -A review of the resident's electronic medical record (EMR) did not reveal documentation indicating if the non-pharmacological pain interventions were effective. The 7/10/24 nurse progress note revealed the resident had pain. She reported her pain as a 7 out of 10. The location of the pain was generalized. The action taken was repositioning, immobilization of the affected area and pain medication. -A review of the resident's EMR did not reveal documentation indicating if the non-pharmacological pain interventions were effective. On 7/11/24, 7/12/24, 7/14/24, 7/15/24, 7/16/24, 7/18/24, 7/21/24 the nurse progress notes revealed the resident had pain. She had a pain level of 2 out of 10. The location of the pain was generalized. The action taken was repositioning, immobilization of the affected area and pain medication. -A review of the resident's EMR revealed repositioning and immobilization were not determined as a personalized pain management intervention. -A review of the resident's EMR did not reveal the facility followed up to see if the repositioning and immobilization interventions were effective. -A review of the resident's July 2024 medication administration record (MAR) revealed pain medication was not administered. The narcotic log book was reviewed on 7/31/24. Oxycodone and tramadol were not administered in July 2024. -However, the nursing progress notes indicated pain medication was administered (see above). II. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 8/1/24 at 10:40 a.m. CNA #5 said if a resident reported they were in pain, she would ask them what their pain was based on a scale of 1 to 10. CNA #5 said she told the nurse and then the nurse told her what the nurse planned to do. CNA #5 said she told the resident what the nurse's plan was to alleviate the pain. CNA #5 said she provided non-pharmacological interventions if the resident could not have pain medication. CNA #5 said the nurse told her what pain relieving interventions to provide for the resident. CNA #5 said Resident #32's pain plan was not documented. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #5 was familiar with Resident #32. She said the resident did not have pain at the moment. CNA #5 said the resident sometimes refused pain medication and the family representative, who was frequently present, helped encourage the resident to take the pain medication. Licensed practical nurse (LPN) #1 was interviewed on 8/1/24 at 9:26 a.m. LPN #1 said she completed pain assessments for residents at admission, during shift change and during medication pass. LPN #1 said she asked the resident where the pain was located, what the level of pain was, if it was acute or chronic pain and what helped the resident's pain improve. Registered nurse (RN) #1 was interviewed on 8/1/24 at 10:32 a.m. RN #1 said a pain assessment was completed every morning during medication pass and as needed throughout the day. She said the residents who had chronic pain told her when they had pain. RN #1 said a pain assessment was completed at admission. She said the pain assessment included what an acceptable pain level was for the resident, where the pain was located and what medication and non-medication interventions relieved the pain. RN #1 said if the resident reported they only wanted pain medications, she documented that in the assessment. RN #1 said she encouraged the residents to use non-pharmacological interventions, such as ice and elevation. RN #1 said typical interventions included ice, elevating, resting and limiting movement. She said she knew if pain medication or non-pharmacological interventions were effective because she followed up with the resident an hour after the medication was administered or an intervention was offered. She said she documented the effectiveness in the progress note. RN #1 said Resident #32 had generalized pain. RN #1 said Resident #32 had pain in her neck, chest and back. RN #1 said the resident used to have little to no pain. She said since the resident received a skin tear on 7/27/24, she had pain more frequently. RN #1 said Advil and tramadol helped the resident when she had pain. She said a calm, quiet and dark environment helped her. The director of nursing (DON) was interviewed on 8/1/24 at 11:01 a.m. The DON said a pain assessment was completed at admission, every seven days and quarterly. The DON said the pain assessment covered the resident's pain level and if the pain was managed. She said non-pharmacological interventions were not personalized to the resident. The DON said the pain assessments were documented in a progress notes. The DON said if the assessment sections were marked as unable to determine, it meant the resident was unable to answer because they were confused. -However, Resident #32 was cognitively intact and was able to answer questions regarding her pain The DON was not aware Resident #32's assessments were marked as unable to determine because the resident was able to answer the questions. The DON said she did not know why the pain assessments revealed the resident had pain in her abdomen. The DON said she was not aware the nurse progress notes documented the resident was administered pain medication but the MAR showed no pain medication was administered. The DON said Resident #32's care plan should have included monitoring if the resident's non-pharmacological interventions were effective and indication that the resident would refuse pain medication. IV. Facility follow up The DON provided the following information on 8/2/24 at approximately 1:54 p.m. (after the survey): (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065427	A. Building B. Wing	08/01/2024

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Center at Park West Llc, The	3727 Parker Blvd Pueblo, CO 81008

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 had a comprehensive pain evaluation every seven days per protocol. The DON said the pain evaluation addressed the location of pain, if the pain was tolerable and if the pain impacted her day-to-day activities. The 8/1/24 nurse progress note revealed the resident said her pain level was a four. The resident said once pain medication was administered, the pain level decreased. The resident had tramadol available as needed. Non-pharmacological interventions were discussed. The resident said she usually dealt with it or took Advil. The resident was asked if repositioning, distraction, music, or cold helped the pain. The resident said the cold made it worse for her and repositioning did not help. -However, the facility did not update the resident's EMR to identify Advil was an effective intervention for the resident. -The facility did not update the pain assessment to demonstrate the resident was able to answer questions in the pain assessment, specifically the quality of pain, effects of pain on the resident's life, aggravating factors, relieving factors and associated symptoms. -The facility did not update the resident's EMR to monitor if non-pharmacological interventions were offered and if the interventions were effective.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure one (#98) of six residents reviewed for unnecessary medications out of 40 sample residents was free from unnecessary medications. Specifically, the facility failed to: -Ensure Resident #98's hours of sleep were documented for psychotropic medication use; and, -Ensure person-centered interventions to address Resident #98's repetitive statements were identified and attempted prior to ordering an antipsychotic medication for the resident. Findings include: I. Resident #98 A. Resident status Resident #98, age 77, was admitted on [DATE], discharged on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included dementia, transient ischemic attack (stroke), cerebral infarction, psychotic disturbance, mood disturbance, insomnia and anxiety. The 5/17/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. He required supervision for oral hygiene and toileting. He required partial assistance for transfers. B. Resident observations During a continuous observation on 7/29/24, beginning at 10:54 a.m. and ending at 11:27 a.m., the following was observed: At 10:54 a.m. Resident #98 was in his room. He said can you help me, help me, help me please. At the nurse's station, directly across from the resident's room, an unidentified nurse said it was time to give him medicine. At 10:55 a.m. the unidentified nurse went into the resident's room with medicine. At 11:00 a.m. the resident left his room in his wheelchair with the unidentified nurse. The nurse assisted him to the activity room. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:02 a.m. Resident #98 tried to go into Resident #99's room, which was next to Resident 98's room. Resident #98 said he needed help. Resident #99 asked him what he needed help with. An unidentified staff member assisted Resident #98 back to the activity room. -There were no activities being conducted in the activity room and the unidentified staff member did not attempt to interact with the resident to determine what the resident needed or provide him with a meaningful activity to distract the resident from his repetitive statements. At 11:19 a.m. the unidentified staff member assisted Resident #98 to his room. The unidentified staff member provided toileting assistance and assisted Resident #98 to his bed. The unidentified staff member left his room. At 11:20 a.m. Resident #98 said help me. There was a certified nurse aide (CNA) who walked past his room and two staff members at the nurse's station. The nurse's station was directly across from Resident #98's room. The resident continued to say help me fifteen times. -The CNA and the two other staff members did not attempt to interact with the resident to determine what the resident needed or provide him with a meaningful activity to distract the resident from his repetitive statements. At 11:22 a.m. Resident #98 said hello. At 11:22 a.m. an unidentified nurse went into the resident's room and asked the resident if he wanted to watch a sports competition (Olympics). At 11:23 a.m. the nurse left the room. From 11:23 a.m. to 11:27 a.m. the resident said help, I need help, and help me and help me, please help me multiple times until an unidentified CNA went into the resident's room. On 7/30/24, Resident #98 was observed throughout the day. The resident was in his bed asleep. On 7/31/24, the following observations of Resident #98 were made: From 12:33 p.m. to 12:35 p.m. the resident was in his bed. He said please help and help me seven times. There were two nurses at the nurse's station across from the resident's room. -Neither nurse provided assistance to the resident. From 3:28 p.m. to 3:30 p.m. the resident was in his bed. He said help and hello, help me. Registered nurse (RN) #1 went into the resident's room and asked him if he wanted to take a nap. C. Record review (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #98's antipsychotic medication care plan, revised 7/28/24, revealed the resident was on an antipsychotic medication related to repetitive statements causing agitation, pacing and delusions disturbing to the patient. The resident would yell out after needs were met. Interventions included administering medications per physician orders, considering a gradual dose reduction when necessary, monitoring as needed for fall risk, monitoring and reporting to the physicians for adverse side effects, offering non-pharmacological interventions and pharmacy to review the drug regimen monthly. -The care plan failed to document what type of delusions the resident exhibited which were disturbing to the resident. -The resident's antipsychotic medication care plan did not include effective non-pharmacological interventions when the resident asked for help. -Further review of the resident's comprehensive care plan revealed there was no care plan to monitor for hours of sleep related to the use of Melatonin for insomnia. The July 2024 CPO revealed the following physician's orders: Melatonin one milligram (mg). Take one tablet as needed for insomnia, ordered on 7/19/24. -There was no physician's order to monitor the hours of sleep. Seroquel 25 mg. Take one tablet by mouth every morning and at bedtime for delirium for seven days, ordered on 7/9/24 and discontinued on 7/11/24. Seroquel 25 mg. Take one tablet by mouth every morning and at bedtime for delirium until 7/16/24 for delusions that are disturbing to the resident, ordered on 7/11/24 and discontinued on 7/16/24. Seroquel 25 mg. Take one tablet by mouth every morning and at bedtime for medical illness with psychotic features for seven days for delusions that are disturbing to the resident and pacing to the point of exhaustion, ordered on 7/19/24 and discontinued on 7/24/24. Seroquel 25 mg. Take one tablet by mouth stat (immediately) for delusions and pacing to the point of exhaustion, ordered on 7/19/24 and discontinued on7/19/24. Seroquel 25 mg. Take one tablet by mouth one time a day for repetitive statements causing agitation for one day, ordered on 7/23/24 and discontinued on 7/24/24. Seroquel 25 mg. Take one tablet by mouth three times a day for medical illness with psychotic features due to delusions that are disturbing to the resident and pacing to the point of exhaustion, ordered on 7/24/24. Antipsychotic medication monitoring. Monitor every shift for signs and symptoms of sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, sweating and loss of appetite, ordered on 7/9/24 and discontinued on 7/18/24. The 7/21/24 nurse progress note revealed melatonin was given and was ineffective. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24 the nurse progress notes revealed the resident called out help me several times after needs were met. It revealed redirection was sometimes effective. -The progress note failed to document if any other interventions were attempted with Resident #98 when redirection was not effective. On 7/29/24 and 7/30/24 the resident called out help me and hello several times after needs were met. It revealed redirection was sometimes effective. -The progress note failed to document if any other interventions were attempted with Resident #98 when redirection was not effective. The 7/27/24 nurse progress note revealed the resident was up at night moving around in his room due to incontinence care that required a bed linen change. The 7/28/24 nurse progress note revealed melatonin was given and was effective. -There were no hours of sleep documented. The 7/31/24 provider progress note revealed the resident had dementia with psychosis. He remained an elopement risk. He required constant supervision and redirection. He was at risk for self harm and wandering into another resident's room. The 8/1/24 provider discharge summary revealed the resident had a challenge during his stay. He continued to have a decline in overall cognitive function. At times, he was redirectable and other times he was not. A few days prior to discharge, nursing noticed increased agitation. The resident continued to yell out for help and had increased restlessness and agitation at night. -A review of the resident's electronic medical record (EMR) did not reveal documentation indicating the resident's hours of sleep were monitored. II. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/1/24 at 8:54 a.m. LPN #2 said she knew a resident had behaviors requiring monitoring based on the diagnosis of dementia, if the psychiatrist saw the resident, at shift change report and monitoring based on protocol. LPN #2 said she was told at shift change if the resident had an active behavior or if the resident was on a psychotropic medication. She said she documented if the resident had behaviors in the resident's EMR. LPN #2 said she knew what interventions to use by asking the resident's physician. She said she tried redirection and guiding as an intervention. She said she would ask the resident what they wanted. LPN #2 said she would ask the family for effective interventions but she said the family did not know what interventions worked most of the time. She said she would notify the MDS coordinator so the care plan was updated. LPN #2 said she was not familiar with Resident #98. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was interviewed on 8/1/24 at 9:26 a.m. LPN #1 said she knew a resident had behaviors requiring monitoring based on her assessment, if the behaviors were in the resident's chart, and the resident's hospital summary. LPN #1 said a dementia diagnosis did not mean a resident had behaviors. She said behaviors were based on how staff approached and interacted with residents. LPN #1 said she knew what interventions to use based on the care plan, on the report form, the CNA task list and the nurses shared at shift change what interventions worked for them. LPN #1 said she tried to put new interventions on the care plan but it was hard to do with the other charting responsibilities. She said it was important to have interventions to keep the resident safe and comfortable. LPN #1 said it was important to give a high quality of life so the resident could improve and go home. LPN #1 said Resident #98 constantly said help but it was not a behavior. She said he did not show distress, discomfort or agitation. She said she held his hand and he continued to say help. She said she added a care plan for the resident saying help repeatedly and his needs were met. LPN #1 said there were no interventions to stop him from saying help. She said everyone was responsible for identifying interventions for Resident #98. The director of nursing (DON) was interviewed on 8/1/24 at 11:01 a.m. The DON said certain diagnoses triggered specific behaviors that needed to be monitored. The DON said the staff knew what interventions to use to stop a behavior based on the psychiatrist visits and what the staff saw during their shift. She said a personalized care plan was important. The DON said the interventions used were based on a list of interventions. The DON said the interventions were not personalized for the residents. The DON said sleep should be monitored anytime a resident was on a hypnotic or on an antipsychotic medication. She said the sleep was documented in the medication and treatment administration records. The DON said she was not aware Resident #98's hours of sleep were not monitored. The DON said Resident #98 often said help me. She said sometimes he said what he needed. The DON said if a resident said help consistently, a personalized intervention should be on the resident's care plan to help address the behavior. The DON said it was important to have interventions to monitor behaviors and sleep so the resident had the best care. She said the resident should have personalized care to stay safe and receive good care. The DON said personalized interventions were important because there were different ways to identify the resident's needs.

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	065427	A. Building B. Wing	08/01/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to meet all of the requirements for the provision of hospice for one (#19) of one resident reviewed for hospice services out of 40 sample residents. Specifically, the facility failed to ensure a hospice care plan was initiated for Resident #19 to determine who was responsible for resident care. Findings include: I. Facility policy and procedure The Care Plan policy, revised 2/8/21, was received by the director of nursing (DON) on 8/1/24 at 10:54 a.m. The policy read in pertinent part, It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan and manage resident care as evidenced by documentation from admission through discharge for each resident. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the patient's strengths, limitations, and goals. The care plan will be specific and appropriate to the individual needs of each resident. The interdisciplinary care plan will be developed through collaborative efforts of the IDT (interdisciplinary team) and other health care professionals. The care plan will be patient centered emphasizing the resident's and/or family's goals. The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate. It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs. (Facility name) will develop, implement, and provide care in accordance with a comprehensive person-centered care plan for the resident consistent with regulatory requirements. The care plan will be modified when needed to meet the resident's current needs, problems, and goals. Any revision, additions, or deletion to the plan of care will be dated. II. Resident #19 A. Resident status Resident #19, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included metabolic encephalopathy and unspecified dementia. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/24/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. He was dependent on staff for assistance with lower body dressing, putting on/taking off footwear, sitting to lying, and sitting to standing, chair/bed to chair transfers, toileting transfers and tub/shower transfers. B. Record review Review of the July 2024 CPO revealed Resident #19 was admitted to hospice services for metabolic encephalopathy, ordered 8/29/24. -Review of Resident #19's comprehensive care plan revealed there was not a care plan for hospice care. The care plan did not indicate which cares the facility would provide versus what cares the hospice services would provide. C. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 8/1/24 at 8:40 a.m. CNA #2 said she knew Resident #19 was receiving hospice care. She said when a resident was receiving hospice care a care plan should be implemented. CNA #2 said she provided basic care for Resident #19 such as repositioning, turning the resident, getting him out of bed and basic hygiene. She said the hospice staff came in on Tuesdays and Fridays. She said if she had any questions or concerns regarding Resident #19 she would call hospice. Registered nurse (RN) #2 was interviewed on 8/1/24 at 8:56 a.m. RN #2 said anytime a resident was receiving hospice care a care plan should be implemented. She said when a resident was admitted to hospice services she would initiate the care plan along with the minimum data set coordinator (MDSC). She said she could add to and update the care plan when she saw any changes. She said she did not know what Resident #19's goals were for care and treatment at the end of life. She said she was not aware that a care plan was not initiated for Resident #19. RN #2 said she was responsible for providing direct patient care, checking on the resident as needed and providing medications and treatments. She said any staff member could communicate with the hospice staff. She said the hospice CNA came in twice a week to shower Resident #19. She said she did not know how often the hospice nurse came in to check on Resident #19. She said the hospice staff came to the facility on a routine basis. She said if she had any concerns regarding Resident #19 she would call the hospice nurse. The director of nursing (DON) was interviewed on 8/1/24 at 9:14 a.m. The DON said when a resident was receiving hospice care a care plan should be implemented. She said the resident should have a hospice initiated care plan and a facility initiated care plan. She said she knew Resident #19 was receiving hospice services. She said she did not know a care plan for the resident's hospice services was not implemented. She said the MDSC and nursing staff were responsible for implementing the care plans. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDSC was interviewed on 8/1/24 at 9:24 a.m. The MDSC said she was responsible for implementing the comprehensive care plans She said she would look at the physician's orders and go off them to determine what needed to be updated on the residents' care plans. She said the care plans should be updated daily and as needed. She said a team that consisted of the DON, the nursing home administrator (NHA), the case manager (CM), the unit manager (UM) and the MDSC met every morning. She said if there was a change of condition the CM and the UM would notify the team. The MDSC said she was not aware that a care plan for hospice was not initiated for Resident #19. She said she did not know how the care plan was missed. She said a change of condition in the MDS assessment was updated but a care plan was never initiated. She said she would make sure that a care plan would be implemented.

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	065427	A. Building B. Wing	08/01/2024

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47350 Based on record review and interviews, the facility failed to ensure in-service training for certified nurse aides (CNA) consisted of annual training for dementia management and/or annual abuse training for three of three out of eight sampled staff. Specifically, the facility failed to ensure: -CNA #3, CNA #4 and CNA #5 completed the annual dementia and abuse training. Findings include: I. Facility policy and procedure The Abuse and Dementia Training policy and procedure was requested from the director of nursing (DON) on 8/1/24 at 12:00 p.m. The policy and procedure was not provided. II. Record review A review of the 5/30/24 dementia training sign in sheet failed to reveal documentation that CNA #3, CNA #4 or CNA #5 had attended the dementia training. A review of the dementia and abuse training documentation on 7/31/24 revealed the following: -The training records revealed CNA #5 had not received dementia and abuse training since 5/25/23. -The training records revealed CNA #4 had not received dementia and abuse training since 6/8/23. -The training records revealed CNA #3 had not received dementia and abuse training since 7/13/23. III. Staff interview The DON was interviewed on 8/1/24 at 8:44 a.m. The DON said abuse training was conducted by the nursing home administrator (NHA) because he was the abuse coordinator. She said he had conducted a recent training on abuse but she was unable to find the documentation or the agenda for the training. She spoke with the NHA and he did not have the documentation. She said a dementia training was completed on 5/30/24 but it did not contain the signatures of CNA #3, CNA #4 or CNA #5. She did not know why those staff members did not complete the training. She said the facility did not have a training policy or procedure for dementia or abuse.